SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: CLICO Ancillary	SERFF Tr Num: MGCC-126242370	State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed	State Tr Num: 43048
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num: CH-26111-IP (06/09) AR	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Courtney Sharp, Kathleen Allen, Jaime Butler	Disposition Date: 07/29/2009
	Date Submitted: 07/24/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/29/2009	Explanation for Other Group Market Type:
	State Status Changed: 07/29/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Please refer to cover letter.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Kathleen Allen, Senior Compliance Analyst
9151 Boulevard 26
North Richland Hills, TX 76180

kathleen.allen@healthmarkets.com
(817) 255-3590 [Phone]
(817) 255-8153[FAX]

Filing Company Information

The Chesapeake Life Insurance Company
9151 Boulevard 26
North Richland Hills, TX 76180
(817) 255-3100 ext. [Phone]

CoCode: 61832
Group Code: 264
Group Name:
FEIN Number: 52-0676509

State of Domicile: Oklahoma
Company Type: Health
State ID Number:

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50.00 policy fee + $50.00 rate filing=$100.00 total filing fee
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	$100.00	07/24/2009	29429895

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/29/2009	07/29/2009

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/29/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Hospital and Surgical Indemnity Policy	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CH-26111-IP (06/09) AR	Policy/Contract/Fraternal Certificate	Hospital and Surgical Indemnity Policy	Initial			CH-26111-IP_0609_AR.pdf

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

HOSPITAL AND SURGICAL INDEMNITY POLICY

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

The attached application is a part of this Policy. Please read it and check it carefully. This Policy is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

10 DAY RIGHT TO EXAMINE THE POLICY

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.

RENEWABILITY

This Policy is guaranteed renewable to age 65, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. [The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.]

PRE-EXISTING CONDITIONS

This Policy does not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least [6 months] after the Effective Date of Coverage for an Insured Person.

NOTICE TO BUYER: This is limited benefit insurance Policy. This Policy provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage. [This Policy does not provide benefits for any loss resulting from a Sickness, as defined, which first manifests itself within the 30 days after the Insured Person's Effective Date of Coverage, until such coverage has been in force for a period of 6 months.]

This Policy is a legal contract between You and Us. **PLEASE READ YOUR POLICY CAREFULLY!**

THIS IS A LIMITED BENEFIT POLICY. PLEASE READ IT CAREFULLY.

TABLE OF CONTENTS

	PAGE
POLICY SCHEDULE	3
DEFINITIONS	8
EFFECTIVE DATE OF COVERAGE	10
PREMIUMS	10
TERMINATION OF COVERAGE	11
BENEFITS	12
EXCLUSIONS AND LIMITATIONS	13
GENERAL PROVISIONS	14

POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.]	EFFECTIVE DATE OF COVERAGE: [01/02/07]
COVERED DEPENDENTS:	EFFECTIVE DATE OF COVERAGE:
[Johnette Doe]	[01/02/07]
[John Doe, Jr.]	[02/15/07]
[Johnita Doe]	[06/22/08]
POLICY NUMBER: [ABC1234567]	POLICY DATE: [01/02/07]
INITIAL PREMIUM: [$0.00]	MODE OF PAYMENT: [Monthly]

SCHEDULE OF BENEFITS

NOTE: **When claims are presented for multiple services performed on the same date, and when only one benefit is payable, We will consider the higher benefit amount, provided claims for such covered services are submitted on a single claim form. Otherwise, claims submitted will be processed based on order of receipt.**

	BENEFIT AMOUNT
INPATIENT HOSPITAL CONFINEMENT BENEFIT: *(not to exceed [365 days] per Sickness or Injury. Confinements separated by less than [31 – 120] days will be considered the same Confinement.):*	
Daily Indemnity Benefit for first [1 - 30] days of Hospital Confinement for Sickness or Injury:	[$100 - $1000] per Insured Person, per day
Daily Indemnity Benefit for [3-365] days of Hospital Confinement:	[$100 - $1000] per Insured Person, per day
OUTPATIENT SURGERY FACILITY BENEFIT:	
Surgery or invasive diagnostic exam with general anesthesia:	[$50 - $500] per Insured Person, per Sickness or Injury
Surgery or invasive diagnostic exam without general anesthesia:	[$50 - $500] per Insured Person, per Sickness or Injury
INVASIVE DIAGNOSTIC EXAM BENEFIT: *(limited to [one] diagnostic procedure per Insured Person, per [day] and [5] diagnostic exams per Policy Year.)*	[$25 - $250] per Insured Person, per diagnostic exam
SURGERY BENEFIT: *(Limited to [one] Surgery procedure per Insured Person, per [day].)*	
Bone	
Bone Marrow biopsy or aspiration	[$25 - $1000] per Insured Person
Removal of knee cartilage	[$25 - $1000] per Insured Person
Total knee replacement	[$25 - $1000] per Insured Person
Total hip replacement	[$25 - $1000] per Insured Person

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

	BENEFIT AMOUNT
SURGERY BENEFIT (Continued):	
Brain	
Burr holes not followed by Surgery	[$100 - $1,500] per Insured Person
Ventriculoperitoneal shunt	[$100 - $1,500] per Insured Person
Exploratory craniotomy	[$100 - $1,500] per Insured Person
Excision of brain tumor	[$100 - $1,500] per Insured Person
Hemispherectomy	[$100 - $1,500] per Insured Person
Breast	
Incisional biopsy	[$50 - $1,000] per Insured Person
Needle biopsy	[$50 - $1,000] per Insured Person
Breast Reduction	[$50 - $1,000] per Insured Person
Lumpectomy	[$50 - $1,000] per Insured Person
Stereotactic biopsy	[$50 - $1,000] per Insured Person
Axillary node dissection	[$50 - $1,000] per Insured Person
Partial mastectomy	[$50 - $1,000] per Insured Person
Breast reconstruction	[$50 - $1,000] per Insured Person
Mastectomy	
Simple	[$50 - $1,000] per Insured Person
Radical	[$50 - $1,000] per Insured Person
Digestive	
Exploratory laparotomy	[$50 - $1,000] per Insured Person
Appendectomy	[$50 - $1,000] per Insured Person
Colostomy	[$50 - $1,000] per Insured Person
ERCP	[$50 - $1,000] per Insured Person
Vagotomy	[$50 - $1,000] per Insured Person
Partial colectomy	[$50 - $1,000] per Insured Person
Colectomy	[$50 - $1,000] per Insured Person
Colectomy with ileostomy	[$50 - $1,000] per Insured Person
Cholecystectomy	[$50 - $1,000] per Insured Person
Esophagectomy	[$50 - $1,000] per Insured Person
Gastrectomy	
Partial	[$50 - $1,000] per Insured Person
Total	[$50 - $1,000] per Insured Person
Ear/Nose	
Tympanotomy	[$25 - $500] per Insured Person
Adenoidectomy	[$25 - $500] per Insured Person
Myringoplasty	[$25 - $500] per Insured Person
Mastoidectomy	
Simple	[$25 - $500] per Insured Person
Radical	[$25 - $500] per Insured Person
Tonsillectomy with or without adenoids	[$25 - $500] per Insured Person

	BENEFIT AMOUNT
SURGERY BENEFIT (Continued):	
Eye	
Cataract	[$50 - $1,000] per Insured Person
Enucleation	[$50 - $1,000] per Insured Person
Corneal Transplant	[$50 - $1,000] per Insured Person
Gynecologic	
D&C	[$25 - $1,000] per Insured Person
Vaginal Hysterectomy	
Partial	[$25 - $1,000] per Insured Person
Total	[$25 - $1,000] per Insured Person
Abdominal hysterectomy with or without tubes and ovaries	[$25 - $1,000] per Insured Person
Vulvectomy	
Partial	[$25 - $1,000] per Insured Person
Radical	[$25 - $1,000] per Insured Person
Heart	
Insertion of pacemaker	[$50 - $1,500] per Insured Person
Angioplasty	
One vessel	[$50 - $1,500] per Insured Person
Two vessels	[$50 - $1,500] per Insured Person
Coronary artery with graft	[$50 - $1,500] per Insured Person
Replacement of aortic or mitral valve	[$50 - $1,500] per Insured Person
Larynx	
Tracheostomy	[$25 - $1,500] per Insured Person
Laryngectomy	[$25 - $1,500] per Insured Person
Laryngectomy with radical neck dissection	[$25 - $1,500] per Insured Person
Liver	
Needle biopsy	[$25 - $1,000] per Insured Person
Wedge biopsy	[$25 - $1,000] per Insured Person
Resection of liver	[$25 - $1,000] per Insured Person
Lungs	
Needle biopsy	[$75 - $1,000] per Insured Person
Thoracotomy	[$75 - $1,000] per Insured Person
Pneumonectomy	[$75 - $1,000] per Insured Person
Wedge resection of lung	[$75 - $1,000] per Insured Person
Lobectomy	[$75 - $1,000] per Insured Person
Lymphatic	
Biopsy lymph node	[$25 - $750] per Insured Person
Splenectomy	[$25 - $750] per Insured Person
Lymphadenectomy (bilateral)	[$25 - $750] per Insured Person

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

	BENEFIT AMOUNT
SURGERY BENEFIT (Continued):	
Miscellaneous	
Foot Surgery	[$50 - $2,000] per Insured Person
Repair of hernia	[$50 - $2,000] per Insured Person
Carpal tunnel release	
One hand	[$50 - $2,000] per Insured Person
Two hands	[$50 - $2,000] per Insured Person
Open reduction fractures	[$50 - $2,000] per Insured Person
Mandibulectomy	[$50 - $2,000] per Insured Person
Organ Transplant (heart, lung/lungs, liver, kidney	
Pancreas, heart/lung or bone marrow)	[$50 - $2,000] per Insured Person
Vasectomy	[$50 - $2,000] per Insured Person
Pancreas	
Jejunostomy	[$75 - $1,500] per Insured Person
Pancreatectomy	[$75 - $1,500] per Insured Person
Whipple procedure	[$75 - $1,500] per Insured Person
Skin	
Biopsy	[$25 - $500] per Insured Person
Excision of lesion of skin	
Without flap or graft	[$25 - $500] per Insured Person
With flap or graft	[$25 - $500] per Insured Person
Spine	
Disectomy	[$200 - $1,000] per Insured Person
Fusions	[$200 - $1,000] per Insured Person
Laminectomy	[$200 - $1,000] per Insured Person
Thyroid	
Biopsy	[$25 - $1,000] per Insured Person
Thyroidectomy	
One lobe	[$25 - $1,000] per Insured Person
Two lobes	[$25 - $1,000] per Insured Person
Urinary	
Biopsy prostate	[$25 - $1,000] per Insured Person
Hydrocele	[$25 - $1,000] per Insured Person
Cystotomy	[$25 - $1,000] per Insured Person
Orchiectomy (unilateral, bilateral)	[$25 - $1,000] per Insured Person
Biopsy of kidney	[$25 - $1,000] per Insured Person
TUR bladder	[$25 - $1,000] per Insured Person
TUR prostate	[$25 - $1,000] per Insured Person
Prostatectomy, radical	[$25 - $1,000] per Insured Person
Cystectomy (bladder)	
Partial	[$25 - $1,000] per Insured Person
Complete	[$25 - $1,000] per Insured Person
Nephrectomy	[$25 - $1,000] per Insured Person

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

	BENEFIT AMOUNT
HOSPITAL REHABILITATION UNIT BENEFIT: *(not to exceed [5 – 30] days per Sickness or Injury and [15 – 45] days per Policy Year.):*	[$25 - $250] per Insured Person, per day
EMERGENCY GROUND/WATER AMBULANCE BENEFIT: *(Limited to [one] trip per Sickness or Injury)*	[$100 - $500] per Insured Person
EMERGENCY AIR AMBULANCE BENEFIT: *(Limited to [one] trip per Sickness or Injury)*	[$1,000 - $5,000] per Insured Person

DEFINITIONS

Ambulance means a ground, water or air vehicle which is licensed as required by law, as an Ambulance, and is equipped to transport Sick or Injured people.

[Attained Age means the Insured Person's age on the most recent annual anniversary of this Policy.]

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Policy unless rates are changed on all Policies issued on the same Class Basis.

Confined/Confinement means an Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital for which a daily charge for room and board is made for each day of Confinement with no discharge or interruption in such Hospital stay.

Cosmetic Surgery means the non-Medically Necessary surgical procedures for the sole purpose of improvement of appearance.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Policy and has not terminated.

Effective Date of Coverage means the date coverage becomes effective under this Policy with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your unmarried natural and adopted children and step-children who reside in Your home for more than 6 months in a year, who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's [24th] birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Hospital means an institution operated pursuant to its license for the care and treatment of sick and injured persons for which a charge is made that the Insured Person is legally obligated to pay. The institution must:

1. Maintain on its premises organized facilities for medical, diagnostic and surgical care for sick and injured persons on an inpatient basis;
2. Maintain a staff of one or more duly licensed Physicians;
3. Provide 24 hour nursing care by or under the supervision of a registered graduate professional nurse (R.N.); and
4. Is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

The term "Hospital" does not include:

1. A hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended care facility; a skilled nursing facility or a facility primarily affording custodial or educational care; care or treatment for persons suffering from mental disease or disorders; care for the aged; or care for persons addicted to drugs or alcohol; and
2. Any military or veteran's hospital, soldier's home or any hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Insured Person is legally required to pay for services in the absence of this insurance coverage.

Immediate Family means the spouse, parent, son, daughter, brother or sister of the Insured Person.

Injury means bodily harm caused by an accident resulting in unforeseen trauma requiring immediate medical attention and is not contributed to, directly or indirectly, by a Sickness.

Insured Person means You or a Covered Dependent under this Policy.

Medically Necessary or Medical Necessity means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice and is not considered experimental or investigative.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder, including but not limited to neurosis, psychoneurosis, psychopathy, psychosis, bipolar Affective Disorder or Autism. Mental or Nervous Disorder does not include Alzheimer's disease or similar forms of dementia resulting from degenerative diseases, stroke, head trauma or viral infection.

Outpatient Surgery Facility means a facility, licensed as such, that provides surgical services on an outpatient basis. This does not include a Physician's or dentist's office, clinic or other such location.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license. A member of the Insured Person's Immediate Family will not be considered a Physician.

Policy means the written description of coverage provided to You.

Policy Year means each consecutive 12 month period beginning with Your Effective Date of Coverage.

Pre-Existing Condition means a medical condition not excluded by name or specific description for which:

1. Medical advice, Consultation, or treatment was recommended by or received from a Physician within the [12 month] period before the Effective Date of Coverage; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the [12 month] period before the Effective Date of Coverage.

Rehabilitation Unit means a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in a rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Sickness means an illness or disease.

Surgery means:

1. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentation's, endoscopic examinations, and other invasive procedures while an Insured Person is under local or general anesthesia;
2. The correction of Fractures and Dislocations; and
3. Any of the procedures designated by Current Procedural Terminology codes as Surgery.

We, Us and Our means The Chesapeake Life Insurance Company.

You, Your, Yours means the primary insured named in the Policy Schedule whose coverage is effective.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

Newborn Children

You or Your Covered Dependent Spouse's newborn child(ren) will be provided coverage after the Policy Date from the moment of birth on the same basis as coverage for other Covered Dependents under the Policy. Coverage for You or Your Covered Dependent Spouse's newborn child(ren) will not continue unless You send written notice directing Us to add the newborn child(ren) to Your Policy. This notice must be received by Us within 90 days of the newborn child's date of birth or before the next premium due date, whichever is later and must be accompanied by any required additional premium. A claim form or Hospital bill does not constitute written notice.

Benefits for Your or Your Covered Dependent spouse's newborn child(ren) will only be for losses due to Sickness or Injury.

Newly Adopted Children

Any minor child under Your charge, care and control for whom You have filed a petition to adopt, will be provided coverage on the same basis as coverage for other Covered Dependents under the Policy. This coverage will begin on the date of the filing of a petition for adoption, if You apply for coverage within sixty (60) days after the filing of such petition; or from the moment of birth, if the petition for adoption and application for coverage is filed within sixty (60) days after the date of birth. Adopted child coverage will be for Accidental Injuries only.

This coverage will terminate upon the dismissal or denial of a petition for adoption.

Additional Dependents

You may add Eligible Dependents by providing evidence of insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent will be shown by endorsement and the date of the endorsement will be the Effective Date of Coverage for the new Eligible Dependent.

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas or any location as designated and communicated by Us. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel the Policy without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period unless and until the premium due is received during the grace period.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given You written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. [The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.]

Waiver of Premium

We will waive all monthly premiums due for the Policy during Your extended Hospital Confinement. The waiver of premium begins after You have been Hospital Confined for a period of at least [30 – 90] consecutive days. Premiums will resume under this Policy when You are no longer receiving a Hospital Confinement benefit under this Policy. Once premiums are resumed under this Policy, any new Hospital Confinements will be subject to a [30 – 90] day continued Confinement without discharge, before premiums will be waived.

Unearned Premiums Refund

Upon the death of an Insured Person, the proceeds payable to the Insured Person or his/her estate shall include premiums paid for insurance coverage for the period beyond the end of the month in which the death occurred. Unearned Premiums shall be paid in a lump sum payment no later than thirty (30) days after the proof of the Insured Person's death has been furnished to Us.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no benefits will be payable under this Policy:

1. At the end of the month for which premium has been paid;
2. On the date You reach age 65;
3. At the end of the month following the date of Our receipt of Your request of termination;
4. On the date of fraud or material misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Premium will only be refunded for any full months paid beyond the termination date.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Policy on:

1. The date Your coverage terminates;
2. At the end of the month following the date such dependent ceases to be an Eligible Dependent;
3. At the end of the month following the date of Our receipt of Your request of termination; or
4. On the date the Covered Dependent:
   a. performs an act or practice that constitutes fraud; or
   b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

Premium will only be refunded for any full months paid beyond the termination date.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

Reinstatement

If coverage under this Policy terminates due to non-payment of premium, We require an application for reinstatement. The reinstatement will not become effective unless We approve such application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Policy or by issuing You a new Policy. In any case, the reinstated coverage provides benefits only for:

1. Injury occurring after the effective date of reinstatement; and
2. Sickness first manifesting itself more than 10 days after the effective date of reinstatement.

BENEFITS

Benefits are payable under this Policy as outlined below, when coverage is in force under this Policy. Unless otherwise stated herein, all benefits are subject to:

1. The Benefit Amount shown in the POLICY SCHEDULE - SCHEDULE OF BENEFITS;
2. Any Benefit limitations shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS;
3. The EXCLUSIONS AND LIMITATIONS listed below; and
4. All other provisions of the Policy.

NOTE: **When claims are presented for multiple services performed on the same date, and when only one benefit is payable, We will consider the higher benefit amount, provided claims for such covered services are submitted on a single claim form. Otherwise, claims submitted will be processed based on order of receipt.**

INPATIENT HOSPITAL CONFINEMENT BENEFIT

When an Insured Person is Hospital Confined due to a Sickness or Injury, We will pay the applicable Inpatient Hospital Confinement Benefit shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS. This benefit is payable per Insured Person for up to [365] days per Sickness or Injury. Readmission to the Hospital for the same Sickness or Injury will be treated as a continuation for the same Sickness or Injury unless separated by [31] days of more. The Inpatient Hospital Confinement Benefit is paid in lieu of and **not** in addition to the Rehabilitation Unit Benefit, per individual date of service.

OUTPATIENT SURGERY FACILITY BENEFIT

When an Insured Person receives Surgery or one of the invasive diagnostic exams shown under the Invasive Diagnostic Exam Benefit below, which is performed on an outpatient basis in an Outpatient Surgery Facility, We will pay the Outpatient Surgery Facility Benefit shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS. The Outpatient Surgery Facility Benefit is paid in lieu of and **not** in addition to the Inpatient Hospital Confinement Benefit, per individual date of service.

INVASIVE DIAGNOSTIC EXAM BENEFIT

When an Insured Person has an [arthroscopy, bronchoscopy, colonoscopy, cystoscopy, gastroscopy, laryngoscopy, sigmoidoscopy, esophagoscopy, laparoscopy, or mediastinoscopy] as a result of a Sickness or Injury, We will pay the Invasive Diagnostic Exam Benefit shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS. Such invasive diagnostic exams must be performed in a Hospital or Outpatient Surgery Facility. Such benefit is limited to [one] diagnostic procedure per Insured Person, [per day] and limited to [5] diagnostic procedures, per Insured Person, per Policy Year.

SURGERY BENEFIT

When an Insured Person receives Surgery related to a Sickness or Injury, We will pay the applicable Surgery Benefit shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS. This Surgery benefit does not include invasive diagnostic exams and is limited to [one] Surgery benefit payable per day.

HOSPITAL REHABILITATION UNIT BENEFIT

When an Insured Person is Hospital Confined and transferred to a bed in a Rehabilitation Unit of a Hospital for the treatment of a Sickness or Injury, We will pay the Hospital Rehabilitation Unit Benefit shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS. Such benefit is limited to [15 days] per Insured Person, [per hospitalization] and [30 days] per Insured Person, per Policy Year. The Hospital Rehabilitation Unit Benefit is paid in lieu of and **not** in addition to the Inpatient Hospital Confinement benefit, per individual date of service.

EMERGENCY GROUND/WATER AMBULANCE BENEFIT

When an Insured Person is transported by ground or water Ambulance to a Hospital emergency room due to Sickness or Injury, We will pay the Emergency Ground/Water Ambulance benefit shown in the POLICY SCHEDULE - SCHEDULE OF BENEFITS. [Limited to [one] trip per Insured Person, per Sickness or Injury.]

EMERGENCY AIR AMBULANCE BENEFIT

When an Insured Person is transported by air Ambulance to a Hospital emergency room due to Sickness or Injury, We will pay the Emergency Ground Ambulance benefit shown in the POLICY SCHEDULE - SCHEDULE OF BENEFITS. [Limited to [one] trip per Insured Person, per Sickness or Injury.]

EXCLUSIONS AND LIMITATIONS

We will not provide any benefits for loss caused by, resulting from or in connection with:

1. Any care not Medically Necessary or benefits which are not specifically provided for in this Policy;
2. Any act of war, declared or undeclared;
3. Active military duty in the service or any country;
4. Participation in a riot, civil commotion or insurrection;
5. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
6. Mental or nervous disorders;
7. Having Cosmetic Surgery or other elective procedures that are not Medically Necessary;
8. Operating any motorized passenger vehicle for wage, compensation or profit;
9. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly;
10. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly;
11. Directly or indirectly engaging in an illegal occupation or illegal activity or Your being incarcerated;
12. Committing or trying to commit a felony;
13. Normal pregnancy, except for complications of pregnancy while Hospital Confined;
14. Hospital Confinement for routine or normal newborn child care;
15. Mountaineering using ropes and/or other equipment, parachuting, hang gliding, officiating or coaching, racing any type of vehicle in an organized or unorganized event, sky diving, scuba diving below 50 feet, motorized racing, para-sailing, experimental aviation, ultra-light flying, base jumping, bungee jumping, heli-skiing or heli-snowboarding; and
16. Travel in or descent from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) certified by the U.S. Federal Aviation Administration (FAA), on a regularly scheduled passenger trip.

Sickness Exclusion

We will not provide benefits for any loss resulting from a Sickness, as defined, which first manifests itself within the 30 days after the Insured Person's Effective Date of Coverage, until such coverage has been in force for a period of 6 months.

Pre-Existing Condition Limitation

We will not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least [6 months] after the Effective Date of Coverage for an Insured Person.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. This Policy;
2. Any applications for the proposed insured individuals; and
3. Any endorsements, amendments or riders attached.

All statements made by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by amendment signed by Us. Changes made in the Policy that are mandated by state for federal law will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 60 days after an Accidental Injury, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to Us at Our administrative office in North Richland Hills, Texas or any location as designated and communicated by Us, within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid upon receipt of proper written proof of loss. Subject to proper written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid upon receipt of proper written proof.

Payment of Claims

We will pay all benefits due under the Policy promptly upon receipt of proper proof of loss.

All indemnities will be payable to the Insured Person. Any accrued indemnities unpaid at the Insured Person's death may, at Our option, be paid to any beneficiary or to the estate of the Insured Person.

Age Misstatement

If Your age has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if You continue to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Physical Examinations and Autopsy

We will, at Our own expense, have the right and opportunity to examine the Insured Person whose Sickness or Injury is the basis of a claim when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

Legal Action

No action at law or in equity will be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Policy; nor may any action be brought after expiration of 3 years after the time written proof of loss is required to be furnished.

Incontestability

After 2 years from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the application will be used to void the coverage, or deny a claim unless the loss was incurred during the first 2 years following such Insured Person's Effective Date of Coverage.

Conformity

Any provision of this Policy which, on the Effective Date of Coverage, is in conflict with the statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:	Attachments
Approved-Closed	Rates	CH-26111-IP (06/09) AR	New		CH-26111-IP (0609) AR 20090721 Rate Page.pdf

The Chesapeake Life Insurance Company

Administrative Office: P.O. Box 982010, North Richland Hills, TX 76182-8010

Hospital and Surgical Indemnity Insurance Policy

CH-26111-IP (06/09) AR

Monthly Premium Rate

Worksite

	Low Option	High Option	Low Option	High Option	Low Option	High Option	Low Option	High Option
	Single		Couple		Single + Child(ren)		Family	
18 - 29	$13.00	$26.00	$26.00	$52.00	$29.00	$58.00	$45.00	$90.00
30 - 39	$15.00	$30.00	$30.00	$60.00	$31.00	$62.00	$49.00	$98.00
40 - 49	$18.00	$36.00	$36.00	$72.00	$35.00	$70.00	$57.00	$114.00
50 - 59	$20.00	$40.00	$40.00	$80.00	$37.00	$74.00	$61.00	$122.00
60 - 64	$26.00	$52.00	$52.00	$104.00	$42.00	$84.00	$72.00	$144.00

Individual

	Low Option	High Option	Low Option	High Option	Low Option	High Option	Low Option	High Option
	Single		Couple		Single + Child(ren)		Family	
18 - 29	$14.00	$28.00	$28.00	$56.00	$30.00	$60.00	$48.00	$96.00
30 - 39	$16.00	$32.00	$32.00	$64.00	$32.00	$64.00	$52.00	$104.00
40 - 49	$20.00	$40.00	$40.00	$80.00	$36.00	$72.00	$60.00	$120.00
50 - 59	$22.00	$44.00	$44.00	$88.00	$39.00	$78.00	$65.00	$130.00
60 - 64	$29.00	$58.00	$58.00	$116.00	$45.00	$90.00	$77.00	$154.00

Multiply the monthly rate by 3 for quarterly rates, 6 for semi-annual, and 12 for annual premium rates.

SERFF Tracking Number:	*MGCC-126242370*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*43048*
Company Tracking Number:	*CH-26111-IP (06/09) AR*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*CLICO Ancillary*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification

Review Status: Approved-Closed 07/29/2009

Comments:
Please refer to attached.

Attachments:
ARGA 0104.pdf
Cert Compl Rule-Reg19 -AR.pdf
Cert Compliance AR-Readability.pdf

Satisfied -Name: Application

Review Status: Approved-Closed 07/29/2009

Comments:
Please refer to attached.

Attachment:
CH-26109-APP _0609_.pdf

Satisfied -Name: Outline of Coverage

Review Status: Approved-Closed 07/29/2009

Comments:
Please refer to attached.

Attachment:
CH-26111-IP _0609_ OC.pdf

Satisfied -Name: Cover letter

Review Status: Approved-Closed 07/29/2009

Comments:
Please refer to attached.

Attachment:
LTR CH-26111-IP _0609_ [Indiv].pdf

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws or another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administra6tion of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders , not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments r4equired by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were wit hteh same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets if the impaired or insolvent insurer.]

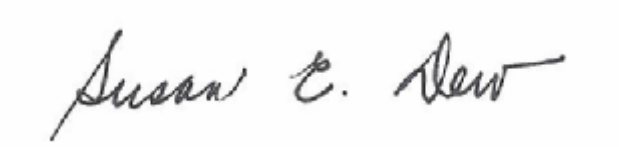
Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH-26111-IP (06/09) AR
CH-26109-APP (06/09)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



_____
Signature of Company Officer

Susan Dew
_____
Name

Senior Vice President, Associate General Counsel and Chief Compliance Officer
_____
Title

July 24, 2009
_____
Date

Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Numbers and Form Names:

CH-26111-IP (06/09) AR – Hospital and Surgical Indemnity Insurance Policy
CH-26109-APP (06/09) - Application

Flesch Reading Score:

50.1 – Policy
51 - Application

Susan Dew, Senior Vice President, Associate General Counsel and Chief Compliance Officer

July 24, 2009

Date

HealthMarkets
Health protection that fits your life.

APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

Primary Applicant Name: _____ _____ _____ Writing Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City _____ State _____ Zip _____ County _____

Daytime Phone (____) _____-_____ Home Phone (____) _____-_____

Cell Phone (____) _____-_____ Fax Number (____) _____-_____

BTTC: ☐ AM ☐ Afternoon ☐ PM ☐ Home ☐ Work ☐ Cell

Email Address _____

Marital Status: ☐ Single ☐ Married

Are all Applicants U.S. Citizens? _____Yes ____No. If "No," explain: _____

How long in the U.S.? _____ Work Permit ____ Visa_____ Type of Visa _____ Expiration Date / /

Occupation/duties of Primary Applicant _____ _____ _____ _____ _____

Occupation/duties of Spouse Applicant _____ _____ _____ _____ _____

SCHEDULE OF FAMILY MEMBERS

Please Print (Full Name)	Sex	Relationship	DOB	Age	Ht.	Wt.	Tobacco use in last 12 months?	Social Security #	ID# *(HO use only)*
(1)		Primary					☐ YES ☐ NO		
(2)							☐ YES ☐ NO		
(3)							☐ YES ☐ NO		
(4)							☐ YES ☐ NO		
(5)							☐ YES ☐ NO		
(6)							☐ YES ☐ NO		
(7)							☐ YES ☐ NO		
(8)							☐ YES ☐ NO		

ProtectFit Plus Plan (CH-26110-IP (06/09)) (Accidental Injury Only Insurance Policy)
☐ High Option ☐ Low Option Family Members ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

HospitalFit Plus Plan (CH-26111-IP (06/09)) (Hospital and Surgical Indemnity Policy)
☐ High Option ☐ Low Option Family Members ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

PersonalFit Plus Plan (CH-26112-IP (06/09)) (Sickness only Scheduled Indemnity Policy)
☐ High Option ☐ Low Option Family Members ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

Vision Plan (CH-26023-IP (5/07)) (Vision Insurance Policy) Family Members ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

Dental Plan (CH-26099- IP (1/08)) (Dental Insurance Policy) Family Members ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
☐ Gold ☐ Silver ☐ Bronze

CancerWise (CH-26055-IP (5/07)) (Cancer Benefit Policy) Family Members ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
First Diagnosis Cancer Benefit Amount: ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

☐ Bill Type ☐ACH (Auth Section Required) ☐Payroll Deduction (WS only) ☐Direct Pay [☐Credit Card]	
☐ Individual Billing / Mode: (If applicable) ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	☐ Payroll Deduction / Mode: (If applicable) ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly
☐ Single ☐ Primary and Spouse ☐ Primary and Child(ren) ☐ Family	Relationship of Payor to Primary Applicant: ☐ Self ☐ Parent/Guardian ☐ Other If "Other" who, and reason for such:_____
For Office Use Only Premium Amount quoted: _____ Check #: _____(if collected at sale)	Proposed Effective Date of Coverage: _____ Special Request(s):_____

1. Has any Applicant ever been convicted or prosecuted for any felony activity? ☐ Yes ☐ No
   *If "Yes," who?*_____ *List details:* _____

2. Are all proposed dependent Applicants (other than Spouse) between the ages of 19 and 24 full-time students? ☐ Yes ☐ No
   If "Yes," name of school(s) _____
   If "No," who? _____ Explain _____
   Is this Applicant(s) incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on the primary Applicant for support and maintenance? ☐ Yes ☐ No

Please skip Questions 3 – 15 if applying for VISION and/or DENTAL only.

3. Is any Applicant eligible for or covered under Medicare or Medicaid? ☐ Yes ☐ No
   If "Yes," Name: _____ *Reason:* ☐ *Financial* ☐ *Medical*

4. Does any Applicant currently have health insurance or has any Applicant had health insurance within the past 12 months? ☐ Yes ☐ No
   If "Yes," ____Group or _____Individual coverage? If "Yes," list Applicant(s) and names of companies, certificate/policy number and types of coverage: _____
   If "Yes," will existing health coverage be replaced or changed if proposed coverage is issued? ☐ Yes ☐ No

Please complete question 5 if applying for the PROTECTFIT PLUS and/or HOSPITALFIT PLUS PLAN:

5. Does any Applicant to be insured currently or in the future plan to participate in any volunteer police or firefighting activities, plan to drive any taxi for wage, compensation or profit, plan to participate in mountaineering using ropes and/or other equipment, parachuting, hang gliding or plan to participate in any hazardous sport or activity for wage, compensation or profit (including officiating or coaching such hazardous sport or activity), or plan on racing any type of vehicle in an organized event? ☐ Yes ☐ No

If any "Yes," indicate Family Member(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Any so designated will NOT be eligible for coverage under the PROTECTFIT PLUS PLAN and/or the HOSPITALFIT PLUS PLAN.

Please complete question 6 if applying for the CANCERWISE, HOSPITALFIT PLUS PLAN and/or the PERSONALFIT PLUS PLAN:

6. Has any Applicant been treated or diagnosed in the past ten years by a Physician for Cancer / Tumor or any benign or malignant growths, including, but not limited to: Cancer, cyst, tumor, leukemia, neoplasm, internal cancer or skin cancer? ☐ Yes ☐ No

If any "Yes," indicate Family Member(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Any person(s) so designated will NOT be eligible for coverage under the CANCERWISE, HOSPITALFIT PLUS PLAN and/or the PERSONALFIT PLUS PLAN.

Please complete questions 7 - 15 if applying for the HOSPITALFIT PLUS PLAN and/or the PERSONALFIT PLUS PLAN:

7. Is any Applicant currently confined in a hospital or nursing home or received recommendation from a Physician to be hospitalized or placed in nursing home? ☐ Yes ☐ No

8. Has any Applicant ever been diagnosed or treated by a Physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an AIDS-related test? ☐ Yes ☐ No

9. Has any Applicant ever been treated or diagnosed by a Physician for: Alzheimer's disease; senile dementia; uncorrected congenital heart defect (excluding mitral valve prolapse); kidney disease (not including kidney stones); systemic lupus; insulin-dependent or medication dependent diabetes; or end stage renal disease? ☐ Yes ☐ No

10. Has any Applicant been treated or diagnosed by a Physician within the last 36 months for: Angina (heart-related chest pain); Heart surgery; Congestive heart failure; Heart Attack; Parkinson's disease; Transient ischemic attack (TIA)(mini-stroke); Stroke; Cerebral vascular insufficiency; Peripheral vascular disease (circulatory problems); Crohn's disease; Emphysema; Ulcerative colitis; Chronic obstructive pulmonary disease (COPD); Musculoskeletal Disorders; Alcoholism, alcohol abuse, drug abuse or drug addiction; Liver disease or disorder (excluding Hepatitis A); Sickle cell anemia; or Uncontrolled hypertension? ☐ Yes ☐ No

11. Is any Applicant or family member (even if not proposed for insurance) now pregnant or an expectant father? ☐ Yes ☐ No
*If "Yes," Who?*_____ *Estimated date of delivery* _____

12. Is any Applicant or family member (even if not proposed for insurance) being tested for or receiving treatment for fertility/infertility, or in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage)? ☐ Yes ☐ No

13. Is any Applicant currently disabled or received treatment or been diagnosed with any neurological disease or disorder, or any muscular disease or disorder including paralysis or lost use of any limbs? ☐ Yes ☐ No

14. Has any Applicant received recommendation from a Physician to be hospitalized or have surgery? ☐ Yes ☐ No

15. During the past two years, has any person to be insured been declined for disability or health insurance or had such insurance rescinded? ☐ Yes ☐ No

For any "Yes" in Questions 7 – 15 indicate the Family Member(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Any so designated will NOT be eligible for coverage under the HOSPITALFIT PLUS PLAN and/or the PERSONALFIT PLUS PLAN.

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the policy is delivered to the Applicant ***while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.***

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Signed ____/____/____ at _____, _____
Date | Resident City | Resident State

X_____ X_____
Signature of Applicant | Signature of Spouse (If to be covered)

TO BE ANSWERED BY AGENT:
I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

X _____

Signature of Licensed Agent | Print Full Name | Agent Number

FOR HOME OFFICE USE ONLY:	
Agency Lead #_____ ☐ Ref. ☐ PDL	Source of Sale ID ☐ Worksite ☐ Retail Outlet ☐Internet/Web ☐Agent Direct ☐ Other_____
Family / Grouping Code ID_____	Association ID _____
Writing Agent ID #:	Alternate Agent of Record ID #:
Grouping Agent ID #:	Product Type:

THE CHESAPEAKE LIFE INSURANCE COMPANY
A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

HOSPITAL AND SURGICAL INDEMNITY POLICY
OUTLINE OF COVERAGE FOR FORM CH-26111-IP (06/09) AR

1. **READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

2. **HOSPITAL AND SURGICAL INDEMNITY COVERAGE –** This coverage is designed to provide You or Your Covered Dependents with coverage for hospital and surgical expenses incurred as a result of a covered Sickness or Injury.

3. **BENEFITS.** The Policy provides the lump sum indemnity Benefit Amount shown in the Policy Schedule for the following benefits. All benefits are subject to the Benefit Amount shown in the Policy Schedule, any benefit limitations shown in the Policy Schedule, the Exclusions and Limitations listed below, and all other provisions of the Policy.

    - **INPATIENT HOSPITAL CONFINEMENT BENEFIT**
    - **OUTPATIENT SURGERY FACILITY BENEFIT**
    - **INVASIVE DIAGNOSTIC EXAM BENEFIT**
    - **SURGERY BENEFIT:**
        - Bone
        - Brain
        - Breast
        - Digestive
        - Ear/Nose
        - Eye
        - Gynecologic
        - Heart
        - Larynx
        - Liver
        - Lungs
        - Lymphatic
        - Miscellaneous
        - Pancreas
        - Skin
        - Spine
        - Thyroid
        - Urinary
    - **HOSPITAL REHABILITATION UNIT BENEFIT**
    - **EMERGENCY GROUND/WATER AMBULANCE BENEFIT**
    - **EMERGENCY AIR AMBULANCE BENEFIT**

4. EXCLUSIONS AND LIMITATIONS. We will not provide any benefits for loss caused by, resulting from or in connection with:

1. Any care not Medically Necessary or benefits which are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Active military duty in the service or any country;
4. Participation in a riot, civil commotion or insurrection;
5. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
6. Mental or nervous disorders;
7. Having Cosmetic Surgery or other elective procedures that are not Medically Necessary;
8. Operating any motorized passenger vehicle for wage, compensation or profit;
9. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly;
10. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly;
11. Directly or indirectly engaging in an illegal occupation or illegal activity or Your being incarcerated;
12. Committing or trying to commit a felony;
13. Normal pregnancy, except for complications of pregnancy while Hospital Confined;
14. Hospital Confinement for routine or normal newborn child care;
15. Mountaineering using ropes and/or other equipment, parachuting, hang gliding, officiating or coaching, racing any type of vehicle in an organized or unorganized event, sky diving, scuba diving below 50 feet, motorized racing, para-sailing, experimental aviation, ultra-light flying, base jumping, bungee jumping, heli-skiing or heli-snowboarding; and
16. Travel in or descent from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) certified by the U.S. Federal Aviation Administration (FAA), on a regularly scheduled passenger trip.

Sickness Exclusion

We will not provide benefits for any loss resulting from a Sickness, as defined, which first manifests itself within the 30 days after the Insured Person's Effective Date of Coverage, until such coverage has been in force for a period of 6 months.

Pre-Existing Condition Limitation

We will not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least [6 months] after the Effective Date of Coverage for an Insured Person.

5. RENEWAL CONDITIONS. The Policy is guaranteed renewable to age 65, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. [The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.]

6. PREMIUMS. We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given You written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. [The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.]

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

July 24, 2009

Arkansas Insurance Department
Life and Health Division
1200 W 3rd Street
Little Rock, AR 72201-1904
Attn.: Life & Health Division, A&H Form Filing Section

Re: SERFF Tracking Number: MGCC-126242370
The Chesapeake Life Insurance Company
NAIC#: 264-61832 / FEIN#: 52-0676509

NEW FORMS	**DESCRIPTION**
CH-26111-IP (06/09) AR	Hospital and Surgical Indemnity Policy
CH-26111-IP (06/09) OC	Outline of Coverage
CH-26109-APP (06/09) AR	Application

Dear Examiner:

The above referenced forms are submitted for your review and approval. These forms are new and not intended to replace any forms previously approved by your Department.

Policy Form **CH-26111-IP (06/09) AR** provides lump sum indemnity benefits for hospital and surgical expenses incurred as a result of a sickness or injury. All benefits are subject to the Benefit Amount shown in the Policy Schedule, any benefit limitations shown in the Policy Schedule, the Exclusions and Limitations of the Policy, and all other provisions of the Policy.

Please note the bracketed items are intended as variable information, and the information enclosed in brackets is our standard for your state. At no time will this bracketed information be arranged in such a way to violate the laws of your state.

Upon approval, we intend to use enclosed application form CH-26109-APP (06/09) to solicit this product. This application may also be used via electronic means.

To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

The required certifications are enclosed herewith. An Actuarial Memorandum and rates are included with this submission.

If you have any questions or if anything further is needed to expedite the review of this filing, please call me collect at (817) 255-3590. Your assistance in this matter is greatly appreciated.

Respectfully submitted,

Kathleen Allen

Kathleen Allen
Senior Compliance Analyst